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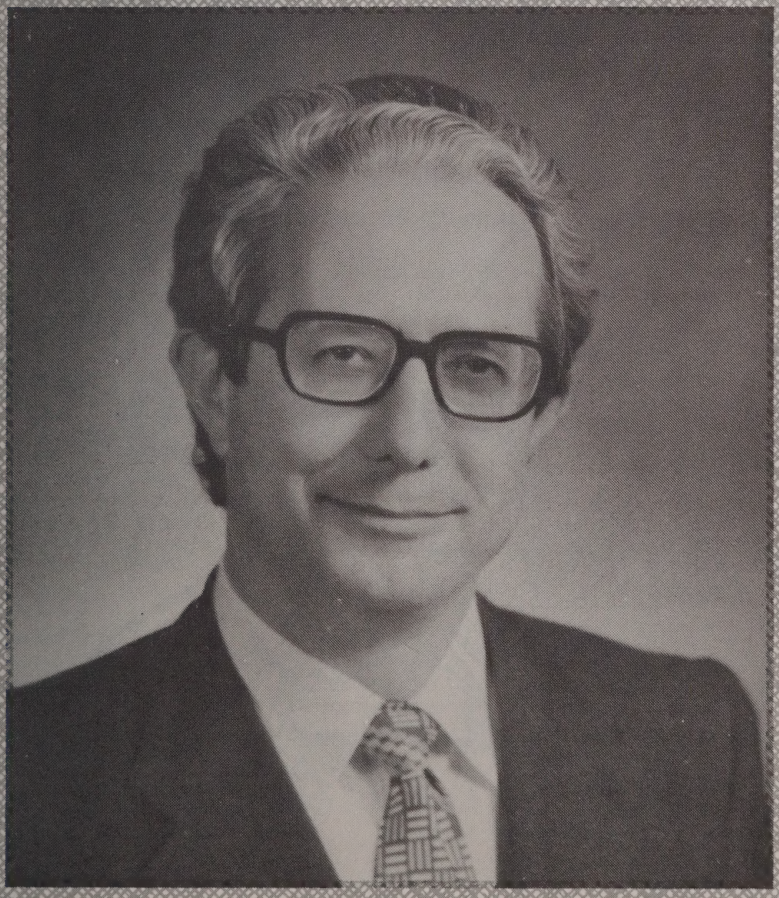

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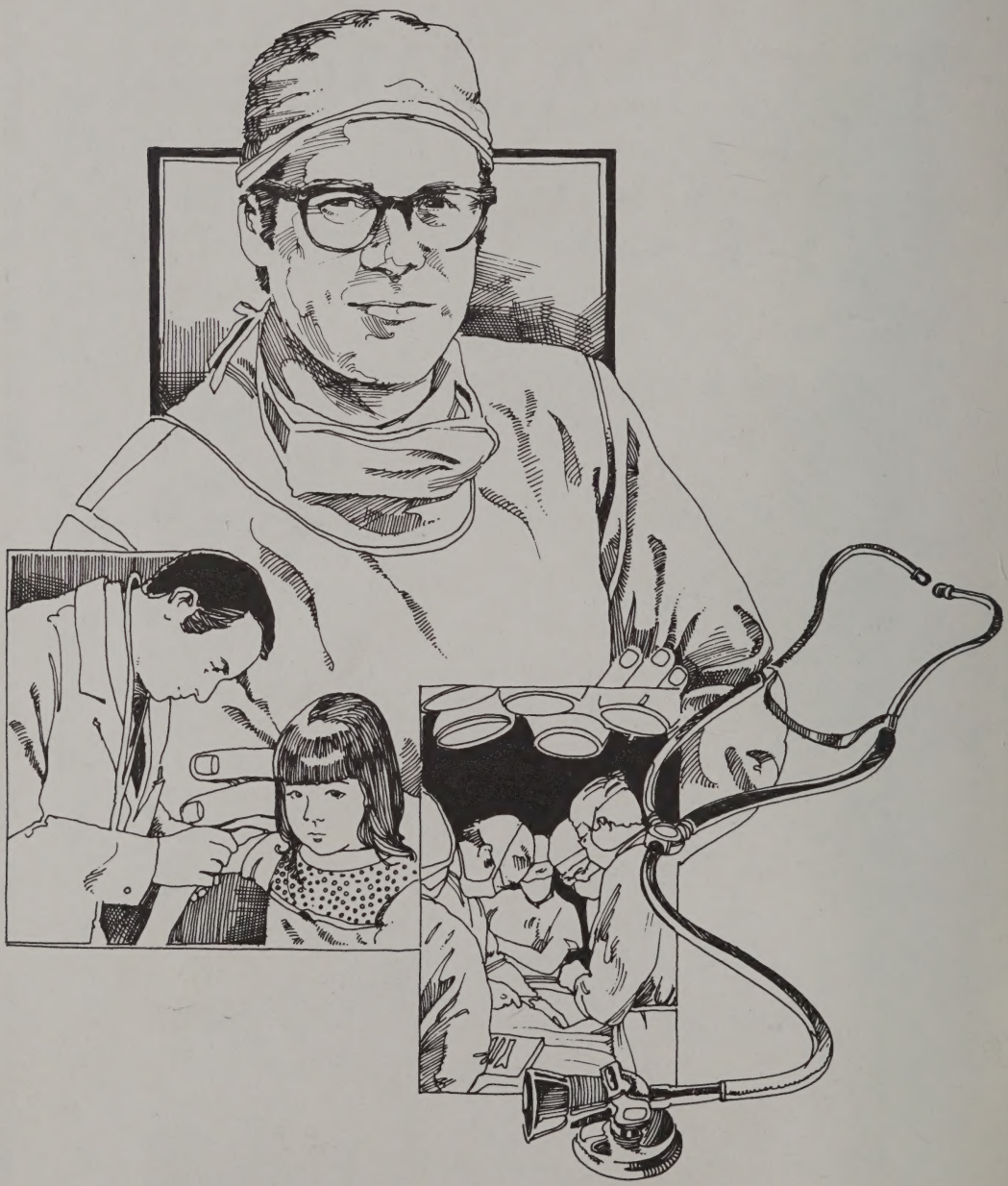

HEALTH PLANNING ISSUE

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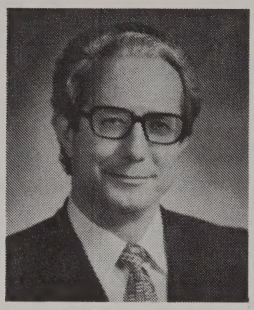

PRESIDENT'S PAGE
Medicine and Politics

"The problem of the others is identical to mine."

Let us scan the American health system as it is today. It is unquestionably good. If we attempt to compare it with any other system in any other nation, it occupies the number one position and this is recognized by foreign authorities. Still there are problems that we have to identify, deal with, and together find solutions for.

The areas of crisis are essentially three: political, technical and economic.

The political crisis stems from the disparity between what people expect from medicine and what they actually receive. Poor information is frequently at the origin of this situation and represents the basis for most pressure movements toward organized medicine. We should indeed "bridge" the trench between medicine and people, between the physician and the needs of the community where he lives. In this direction it will be the duty and general policy of our district medical society while leaving the technological-curative aspect of medicine essentially to our hospitals, to strengthen the aspect of preventive medicine, a task in which every member should be constructively involved. We should unite with the community and keep focus on health problems in general.

If the mission of our medical society is indeed one to solve problems and not merely to hold meetings or present lectures, then we should expect that the vast majority of its members become involved and not remain strictly "checkbook members".

The technical crisis is due to medical progress in all of its scientific aspects. The rapid evolution of medical knowledge and the changes in the systems of health-protection are giving an essential role to continuing medical education. Physicians will be surpassed if they do not maintain during all of their lives an intelligent apprenticeship. It will be the duty of the Hampden District Medical Soceity to help its members to develop knowledge and skill in whatever field they operate. In this sense our ideal is not a periodic recycling of general of specific subjects rather we intend the organization within our area: 1. to be a true continuous exposure to current notions. 2. We will stimulate the membership to take full advantage of conferences, symposiums, seminars and grand rounds offered by our hospitals and by the nearby available institutes of learning. The economic crisis is upon us and though the physicians receive only about 20% of the health care dollar, they unquestionably control or influence most of the rest. Physicians are indeed the primary decision makers in the health care system. It is true that until now very little responsibility has been given to us in regard to

the economic consequences of health care decisions. We have not been trained in medical economics. Most of our colleagues still have no idea what hospital, pharmaceutical, or other ancillary care costs actually are. Our system gives to the physician little or no incentive to find out or to act on this information. We must also admit that frequently our professional values combine with some financial incentives and other factors like the malpractice threat (just to mention one of them) act to minimize concern over cost and foster cost-increasing behavior. The Hampden District Medical Society will implement and encourage concern for cost effectiveness. At least two HMO's are now operating in our area and many additional feasibility studies are in the process of evaluation with the obvious intent of creating the formation of a health delivery system in strong competition with the private insurance sector.

It will be the duty and task of the Hampden District Medical Society to monitor all of these problems, and encourage competition and cost-containment strategies. In no way will there ever be acceptance or permissiveness of anything to impose a decline in the level of the top medical care which the citizens of our community are entitled to receive.

Nineteen years ago when I came to Hampden County there were physicians in solo or partnership practice who had essentially one problem, "time", and the time-pressure was such as to make it difficult for many of them to cope. Today, in one form or another most of our colleagues practice in large or small groups and it is possible to go out in the evenings, get away on weekends and to take regular vacations. Specific personnel in our offices seem capable of handling the inundation of our paperwork. In summary, the actual practice of medicine is probably more pleasant today, and many of us could become not only healers of the sick, but also promoters of the welfare of the community. □

FRANCO NAVAZIO, M.D.
President-Elect

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Western Massachusetts Health Planning Council, Inc.

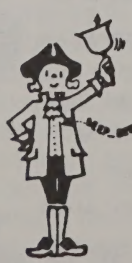
The National Health Planning and Resource Development Act (P.L. 93-641) became law in January 1975. It created a National Council on Health Planning to advise the Secretary of Health, Education and Welfare; it required the designation in every state of a State Health Planning and Development Agency (the Department of Public Health in Massachusetts); it called for each Governor to appoint a State Health Coordinating Council to develop a State Health Plan; and finally, the law mandated the formation of local Health Systems Agencies throughout the nation.

There were many reasons why this law was passed but chief among them was widespread agreement on the need for planning in the health care system and in addition a growing alarm at the unusually rapid rate of cost escalation in that system. The latter concern has become even more sharply realized in these days of severe inflation.

The basic functions of a Health Systems Agency are three: data analysis, plan development and review of both institutional health services and the proposed uses of federal health funds. It is the review function that provokes a great deal of public attention (and sometimes controversy) especially when a project is turned down. But it should be remembered that most reviews result in approvals.

Important as the review function is, it is the plan development function that is most crucial since it lays down a pattern for the development of services, institutions and programs to assure the highest level of wellness and the best degree of medical care possible within the constraints of available financial and other resources.

Achieving that goal is an extremely difficult enterprise. In fact, as a goal, it can never be fully realized but is to be worked toward in every possible way. The process of moving toward that goal is a cyclical one involving the repetition of planning steps (probably every three years) and - most important - the process requires human judgment at each step.



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The chief element of P.L. 93-641 is that it recognizes the need for those judgments but at the same time does not place the responsibility for those judgments in any single individual's hands nor in the hands of any single interest group. Thus, the American health planning process is not highly centralized nor is it controlled by bureaucrats. In short, American planning is in the hands of the entire community including both the consumers of services as well as the providers of those services.

Thus, the Board of Directors, the three sub-area Advisors groups and many committees include physicians among their membership. In particular the HDMS has had and continues to have members on various bodies of the WMHPC and will shortly have a member elected to the Board of Directors. Their service and input is important and valued.

The planning process is a difficult and complicated one that requires many hard decisions on the part of the community to achieve the results the community desires. Physicians have an important part to play in that process and the WMHPC looks forward to their continued committment and involvement. □

HERBERT HOOVEN
Executive Director

PERSONAL CARE ASSISTANCE

Personal Care Assistance is a new service offered to severely disabled wheelchair-bound residents of the Pioneer Valley region by the Stavros Foundation-PCA Project.

Funded by Medicaid, Personal Care Assistance allows disabled people to hire, train, and manage their own personal care assistants (PCAs). The duties of a PCA may include assistance with dressing, bathing, grooming, transfers in and out of wheelchairs, meal preparations, and household chores. The disabled person is both the consumer of the service, since she receives money from Medicaid to hire his/her own PCAs, and the employer, since s/he chooses whom s/he will hire. This situation allows flexibility and self-determination for the consumer in meeting personal care needs, as well as enabling him/her to live independent of institutional facilities.

In order to be eligible for PCA services a disabled person must be: Medicaid eligible; a resident of Hampden, Hampshire, or Franklin counties; wheelchair-bound for purposes of mobility; age 18 or older; and in need of such services to maintain independence outside of institutional facilities.

If you know of someone who may need PCA services and qualifies by meeting the above basic eligibility requirements, or if you are interested in more information about PCA, please call the PCA Project Office in Turners Falls at 863-2240. The office is open from 8:30 to 4:30, Monday through Friday. The PCA Project staff will be happy to assist you and answer any questions you may have. □

HEALTH PLANNING

AMA TO PROPOSE AMENDMENTS TO P.L. 93-641

The Board of Trustees of the American Medical Association has recently approved a series of proposed amendments to P.L. 93-641, for introduction into the 96th Congress. The AMA amendments generally seek to: alter the composition of planning agency governing bodies; limit federal financial support, while increasing opportunities for local funding to health planning agencies; strengthen the role of state governors in the health planning process and address certificate of need procedures for the development of health maintenance organizations (HMOs).

Specific amendments would alter the definition of the term "provider of health care" by eliminating the category of "indirect provider" from the law, while requiring that 40% of the "direct providers" on HSA governing bodies be practicing physicians. To lessen federal financial control of HSA activities, another amendment would limit the federal share of HSA costs to 75%, while allowing maximum flexibility for HSAs to seek the balance of costs from state and local sources.

A series of amendments will be introduced to enlarge and enhance the role of state governments in the health planning program. Under these proposed amendments, interestate HSAs would be prohibited without the consent of the Governors of all states involved. State governors would also have final approval over the designation of HSA boundaries, and a mechanism would be provided to revise boundaries. In addition, the Governor of each state would be empowered to approve state health plans or any revisions in such plans. A separate amendment calls for different staffing for the Statewide Health Coordination Council (SHCC) and the State Health Planning and Development Agency (SHPDA). Under this proposed amendment, a mechanism would be provided for the SHCC to serve as an appeals body in the event of conflicting decisions by HSAs and the SHPDA over certificate of need applications.

P.L. 93-641 now defines "institutional health services" to include health maintenance organizations (HMOs), requiring approval of a certificate of need application for initial establishment of an HMO. An AMA- designed amendment would alter this definition to exempt the initial establishment of HMOs from certificate of need (CON) requirements; however, a certificate of need would be required for development of HMO inpatient facilities. Another proposed amendment would delete the present requirement that HSAs and SHPDAs consider the "special needs and circumstances" of HMOs in making CON reviews, appropriateness reviews or reviewing grant applications.

Copies of AMA amendments to P.L. 93-641 are available upon request to the AMA Department of Community Health Systems. □

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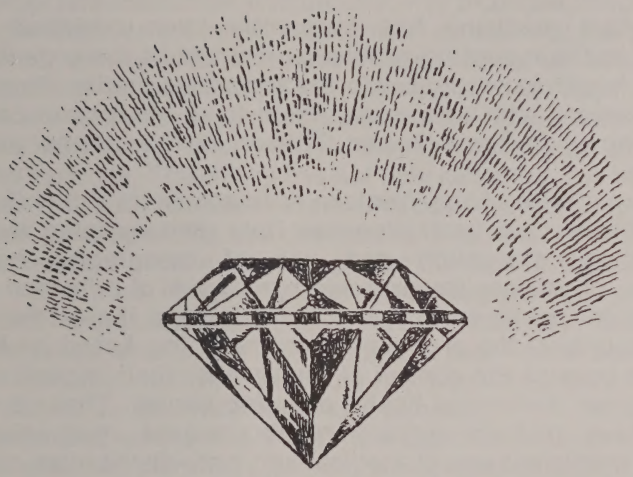

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District Supervisor

THE PSRO ROLE IN HEALTH SYSTEM PLANNING

Organized medicine has frequently been criticized as being indifferent to the mounting problems inherent in the organization and delivery of health care services to the American public. Physicians and the organizations which represent them have often been compared to Nero fiddling while Rome burned. This criticism is neither accurate nor defendable.

The experience of the Western Massachusetts P.S.R.O., Inc. as a regional physicians organization has fully demonstrated that through the collection, evaluation and use of meaningful health care information, physicians can exercise a great deal of influence over many problems of the health care system. Nevertheless, it must be recognized that the majority of the problems inherent in the American health care system are beyond the control of physicians, their organizations, and even consumer dominated health planning bodies. These problems, to name a few, include current reimbursement mechanisms which encourage inefficient use of medical services, distribution of resources (i.e. , physicians, facilities, beds) within a given area which affect utilization and cost, and the utilization of highly technical resources.

Although these care system problems exist and frequently confound even the best health care planners, be they physicians or non-physicians, there is growing evidence that the activities of an effective PSRO program can promote the goal of effective health planning.

The Western Massachusetts P.S.R.O. has had an operational peer review program since 1976. While the peer review program is best known for its hospital and physician review activities, a less well known but as significant area of activity has been the PSRO's collection and analysis of medical data. Following the discharge of Medicare and Medicaid patients from the hospital, the PSRO collects a uniform set of health care information. With the help of a sophisticated computer system, the PSRO develops numerous displays and profiles of health care activity throughout the region. These displays provide the opportunity to evaluate regional trends in the utilization of health care services. In addition, PSROs throughout the country submit regional information to a central, national data processing source to enable comparisions of utilization trends within states and between states. The net result of the accumulation and dissemination of this information is to place the PSRO in the position of having and providing sound, accurate and meaningful utilization data which can be of significant help in understanding the mechanics of the current health care system, and in evaluating the quality and appropriateness of patient care.

At the local level, in western Massachusetts for example, the PSRO has the ability to identify trends in health utilization by patients, trends in methods of health care delivery by physicians, and trends in diagnostic and procedural specific utilization by hospitals. This

information can be used for numerous purposes; and even with the built in limitation which restricts data collection to Medicare and Medicaid patients only, the information does provide sufficient guidance in terms of "where to look further" for more in depth analyses of health care needs, appropriate utilization and quality. For example, since 1976, the PSRO has consistently collected information concerning the problem of so called "administratively necessary days" used by Medicare and Medicaid patients in hospitals. These are defined as days of hospital care which are not medically justified at the acute care level, but nevertheless are used because of the unavailability of alternate non-hospital services. The PSRO has not only collected this information, but has shared it with local and statewide political leaders, and health planning and state agencies and the media. The result of this publicity has been to create a growing awareness on the part of both the medical community and the public about the expanding problem of administrative days and the resulting unnecessary costs to the Massachusetts taxpayers. The PSRO is aware that health planners have used this information and that the state has welcomed the attention the PSRO has played to this very important subject.

A second area where the PSRO has been able to demonstrate a potential to assist in planning, is the development of utilization trends by hospital and by the residence of patients throughout Western Massachusetts. These studies, which are commonly referred to as patient origin studies, are extremely useful for purposes of determining hospital service areas. In addition, if properly designed, they can identify the reasons for migration into a given facility. On a regional level (i.e., state or multi-state level), these studies can identify the services being provided to patients hospitalized outside a local area. The availability to this type of current information can be of great use to hospitals and planning organizations as they prepare for their future needs.

These are but two examples of the many areas of the health care arena, which through the collection, analysis and dissemination of health care information, can provide a mechanism to promote improvement in the appropriate utilization of medical services. Clearly, the experience of the Western Massachusetts P.S.R.O. proves that Nero is neither fiddling nor is Rome burning. □

CHARLES E. EVERETT, Executive Director
and
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History of The Springfield South End Community Health Center Development Corporation

Surveys conducted in 1974 and in 1975, relative to health care in the South End neighborhood of Springfield, Mass. revealed, 55.6% utilized emergency rooms for medical attention, 2% used health clinics operating in other parts of the city, and 70% indicated that they would use and support a neighborhood health center (NHC). Combined with other evidence, these figures revealed a crucial need for improving health services; thus, the South End Coalition was formed in 1974.

In December of 1974, the coalition sponsored a health screening clinic (i.e. Hypertension, Breast cancer, etc.) The Brightwood-Riverview Health Center, the Wesson Women's Hospital, the Medical Center of Western Massachusetts (now Baystate Medical Center), and the U. Mass. School of Nursing cooperated to make the clinic, attended by over two hundred people, an overwhelming success. Meanwhile, members of the coalition began meeting with representitives of the Department of Community Affairs, the Springfield Department of Human Services, and the South End Community Center (S.E.C.C.), in addition to those afore-mentioned agencies. The Western Mass. Medical Center at that time expressed an interst in developing a relationship with or sponsorship of a South End Clinic.

A Documented Proposal for a Neighbor Health Center in the South End [January 1975], requesting Community Development Block Grant funds through Human Services, was dropped. By October, 1975, the Medical Center had lost interest in the project. However, in March of 1976, Wesson Hospital revealed a draft of a sponsorship proposal for the South End Health Center with the city funding and community policy making. The South End Action Committee Citizens Council (an elected body) listed a health center in the neighborhood as number one priority for Community Development funds. Wesson's Proposal has since been forgotten with its merger to form Baystate Medical Center, yet the Coalition continued its efforts for a free-standing health center.

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In the Spring of 1976, a request by the Dept. of Human Services for projected proposals to be funded in the South End under the Year II Community Development Block Grant Program listed a "health center with sliding fee scale" as the only major project; a letter dated April 29, 1976, from the Director of Human Services, Jeanne J. Bass, stated that "the City of Springfield intends to keep its commitment to assist in this process" of starting a "needed" health center "through" technical and funding action" and that the deadline for this proposal was extended "indefinitely". **The Ambulatory Care Task Force Report for the City of Springfield,** prepared by The Western Mass. Health Planning Council (W.M.H.P.C.) in August of 1976, recommended a "health care facility providing a minimum range of basic practice services" for the South End. Later, the same year, the Federal Register (Vol. 41, No. 201 listed census of tracts 8011, 8020.00 and 8019 (Maple and High Street neighborhood, part of catchment area) as "medically underserved".

After releasing their ambulatory study, the W.M.H.P.C. began public hearing on needs in the area. Also in this time, outreach work concerning a N.H.C. in the South End was started. This was a followup effort to a health survey and a screening clinic conducted by the Coalition in the spring. In September, the Coalition began the preparation of the Certificate of Need for presentation before the State. This was an ongoing project for the next year with the certificate being filed September 1, 1977. This period of preparation was a time of contacting agencies to be involved in the referral system soliciting letters of endorsement and informing the public. It was also the time in which the process of incorporation was initiated. Articles of Organization were signed March 23, 1977.

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During the summer of 1977, weekly meetings were scheduled with South End residents and with the Western Mass. Legal Service for the purpose of informing both parties of th corporations' progress. Efforts were intensified to secure various sources of funding and the remainder of the summer was utilized for the final preparations of the Certificate of Need.

The SSECHCDC has been working closely with the Human Services Dept. and the WMHPC since the C.O.N. has been submitted. Together these agencies have been attempting to cooperate fully with the Determination of Need Program of the Commonwealth's Dept. of Public Health. These efforts have included answering relative questions by telephone and writing, along with several meetings having been held. Currently (in 1977) the SSEHCDC is trying its best to solidify its C.o. N. for presentation before the Dept. of Public Health at a hearing. The projected date of this hearing of determination is early autumn.

Written answers are being prepared for **all** inquiries, and agreements between the SSECHCDC and participating referral services are being finalized. All of these efforts have been intensified in the hope of a ''solid'' C.o.N. and the resulting approval of certificate shortly.*

The South End Community Center

The relationship between the South End Community Center and the Springfield South End Community Development Corporation is strictly one of landlord-tenant; the SECC is the lessor the SSECHCDC is the Lessee of the attached lease, dated September 28, 1977. Clearly, there are no arrangements for joint health care programs!

*The Determination of Need was approved on December 19, 1978. City Development funds have been alloted for renovations to establish a Health Center in the South End.

Presently, the corporation is concerned with educating the community residents to the concept of preventive health care. To accomplish this, a series of free health screenings and workshops will be planned.

The center's initial goal will be to provide a minimum range of basic family practice services. These services will be extended as utilization and financial viability warrants. The initial clinic services will include: Dental, i.e., cleaning, screening, referral and education and those services performed by family and nurse practitioner. The clinic will be open for 16 hrs. a week during the evenings and weekends.

The South End Community Health Center is not intended to be a comprehensive care center. It is not designed or equipped to perform comprehensive evaluation or to provide emergency care. The center will be a referral pathway however for those patients requiring secondary,

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tertiary, and emergency care. The center will provide initial and continual primary care for adult and pediatric patients from the South End as well as other neighborhood of the city. Presently at this time the Health Center is begining its search for interest and qualified physicians specializing in family practice to staff part time the center.

A very successful health fair was held on Tuesday, March 13, 1979 at the Springfield South End Community Center. This event was organized and coordinated by the South End Health Center Development Corporation. The goals of the fair included education of the South End population concerning preventive health care and providing needed medical screening for community residents.

Seven screenings were offered: glaucoma, hearing, lead paint, diabetes, Tuberculosis, hypertension and podiatry. Approximately 700 screenings were performed. The most popular were hypertension with 184 tests, T.B. with 135 tests and hearing with 102. More than half present had at least two tests performed. Many local agencies, business and individuals gave assistance and were supportive in this community effort. A partial list includes: Cancer Society, Heart Association, Diabetes Association, University of Mass. School of Nursing, Red Cross, Saratoga Drugs, Friendly's and Dr. Michael Haynes.

This health fair was a major undertaking in preparation for the opening of the South End Health Center in March of 1980, as a primary care neighborhood health center. The center will occupy approximately 3,800 sq. ft. of floor space with handicap entrances and exits, reception and waiting areas, offices, examining and treatment rooms, handwashing and toilet facilities, storage facilities and equipment rooms. □

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EXECUTIVE COMMITTEE MEETING
April 17, 1979

The Executive Committee of the Hampden District Medical Society met on Tuesday, April 17, 1979 in the Conference Room.

Present were Drs. Navazio, Stoddard, Walthall, Magill, Dasco, Zadworny and Mrs. Purdy.

The minutes of the March meeting had been mailed to the committee and were accepted as written.

Dr. Paul Stagg was present and gave a report of the Western Massachusetts Health Planning Council Ambulatory Care Committee. He suggested more representation from the physicians on the committees. After discussion it was voted by the committee to invite Mr. Herbert Hooven to the May meeting. Dr. Navazio suggested that Dr. Stagg attend the May meeting also.

Dr. Dasco gave a report of the Executive meeting of the Massachusetts Medical Society held on Wednesday, April 11, 1979 in Boston. More about the Members' Insurance committee will be discussed at the Council. The Blue Shield lawsuit was heard and it was recommended that the suit should be presented to the Insurance Commissioner. Discussion of this will also be held at the Council meeting in May.

Correspondence

Health Insurance Association of America wrote asking if the Hampden District Medical Society wishes to be listed in their manual of Peer Review committees. However, due to closing the medical Charges and Peer Review Committee this committee does not exist anymore.

A letter from Blue Cross thanking the Hampden District Medical Soceity for its participation in the Heimlich maneuver program was read and accepted by the committee.

Old Business

The Impaired Physician Committee of the Massachusetts Medical Society is to hold a meeting in Boston on Wednesday, April 25. Dr. Flahive will attend this and report back to the Executive Committee at the May meeting.

The question of Nutrition in Wilbraham schools as questioned by a resident was answered by Dr. Willcutts in an answer from Dr. Jean Mayer. The original letter will be answered to the initial inquirer.

Dr. Navazio gave a report of the visit made to the York Street Jail. Drs. Flahive, Navazio, Mrs. Miller, Mrs. Medrek and Mrs. Purdy met with Sheriff Ashe and Terry Aberdale. The health aspect is being covered adequately at present by three physicians from the Emergency physicians from Baystate Medical Center. The new hospital facility will

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be started in late summer and Mr. Ashe will contact the medical society again at that time for additonal help.

In the absence of Dr. Remsberg who was ill, Mrs. Purdy gave the financial report for the ending of the fiscal year dated April 1, 1979.

The Board of Registration in Medicine answered the questions presented last month. They feel that the lecturer should receive more credits than the participant, but they also felt that this was the only way it could insure all the physicians that a uniform policy would be adopted to grant the equivalent number of credits for the physicians teaching a course as well as the audience attending the course. Also, the board will accept recertification by a specialty board which meets or exceeds the AMA or AOA criteria for continuing medical education within the immediate preceeding three years. Anyone becoming re-certified between 1977 and 1980 has fulfilled the requirement for re-registration in 1980.

New Business

Mr. Berte of Civil Defense asked verbally if the physicians thought there should be a 24 hour service available for nuclear accident. The committee feels this is entirely a Civil Defense problem.

The Selective World Tours, Inc. have offered two trips, one to Yugoslavia and one to Egypt to the district society. However, the committee feels that there are enough going on a state level and those offered by the specialty societies and that Hampden should not get involved.

There being no other business the meeting was adjourned at 9:10 P.M. □

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ANNUAL DISTRICT MEETING
April 24, 1979

The 139th Annual Meeting of the HDMS was called to order by Dr. Flahive, President at 6:25 P.M. on Tuesday, April 24, 1979 at Chez Josef in Agawam, Massachusetts.

The minutes of the February 6, 1979 district meeting were read by Dr. Stoddard, Secretary and accepted by the membership as read.

All Annual Committee reports having been printed in the April issue of the Hampden Hippocrat were accepted by the membership as written.

Dr. Memery, Chairman of the By-Laws Committee presented a suggested by-law change. In order to conform with the by-laws of the Massachusetts Medical Society it was necessary to delete Chapter III, Section 5, JUNIOR MEMBERS. A motion was made and seconded to delete this section and the membership voted in the affirmative.

Dr. Flahive, President asked Dr. Remsberg, Treasurer, to give his Annual Report. This report is filed with the Treasurer. The budget for 1979-1980 has been approved by the Executive Committee and the committee voted to keep the dues as their present level of $100.00 per year.

Dr. Moore, Auditor, reported that he found the books to be in order and the report was accepted as a whole.

Dr. Flahive gave a few farewell remarks and indicated that being President was not too burdensome a job.

In the absence of Dr. Fitzpatrick, Nominating Chairman, Dr. Stoddard gave the report of the slate of officers and councilors for the year 1979-1980. There were no nominations from the floor and the membership voted for the slate as presented. (Printed in May issue of Hampden Hippocrat)

Dr. Flahive introduced Dr. Navazio, incoming President of HDMS, who presented a plaque to Dr. Flahive and offered thanks for his excellent leadership during the past year.

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A motion was made to adjourn the business meeting and the membership voted in the affirmative.

After a brief social hour dinner was served.

After a most delicious repast, Dr. Flahive introduced the head table and the special table of guests.

There were twenty two new members who received certificates of membership.

Awards were made to two news media persons, William Scaife of the Morning Union and Jim Kontoleon, Vice President and General Manager of WHYN TV. They received recognition for their public service in Medicine.

An award for fifty year membership in HDMS was to be presented to Dr. Lawrence H. Doolittle. However, Dr. Doolittle was unable to be present and his award will be mailed to him.

Dr. Flahive announced that Dr. Sannella recently celebrated his 90th birthday and had been in practice for 61 years and is considering retiring.

Dr. Flahive introduced the speaker for the evening, Miss Betty Jane Anderson, Assistant Counsel for American Medical Association. Her topic was "Medicine in a Litigious Climate." Miss Anderson spoke about the FTC, its origin and its discovery of the medical profession. Many problems are involved in today's medicine.

The meeting was adjourned at 10:20 P.M. □

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In Memoriam

WILFRED D. MACDONALD, M.D.

Wilfred D. MacDonald, M.D. died March 14, 1979 at the Soldier's Home in Holyoke, Massachusetts.

Born in Cambridge, he received his secondary education from Wakefield High School and received his medical degree from Tufts University School of Medicine.

Dr. MacDonald served during World War II as a Captain in the Army. After the war he settled in Worcester and practiced Internal Medicine and Cardiology. He was on the staff of Worcester City Hospital.

Dr. MacDonald was Past President of the Worcester District Medical Society, and practiced in Worcester for twenty-seven years before transferring to Hampden District Medical Socity in 1973 to accept a position at Soldier's Home. He was a member of the American Medical Association, the Massachusetts Medical Society and Tufts Alumni Association.

Deepest sympathy is extended to his family and many friends from the Hampden District Medical Society. □

SPECIAL OLYMPIC'S

There are 160,000 Massachusetts residents who are mentally retarded.

The Special Olympics began ten years ago in an effort to prove that mentally retarded persons can achieve athletic--and personal success. That initial effort did prove successful and now Massachusetts is a national leader in providing varied athletic and recreational experiences for our Special Olympians.

In 1978, the Massachusetts Special Olympics supported 137 meets, ranging from local competition to state-wide events, with 9,950 mentally retarded persons of all ages particiating.

Now we are preparing for the 1979 International Special Olympics in Brockport, N.Y. August 8 to 13. Massachusetts plans to field a team of 100 Special Olympians for this important meet at a cost of nearly $50,000.

Because Massachusetts Special Olympics does not benefit from such community funding as The United Way, we are faced with raising the $50,000.00 ourselves. It is a difficult task and we need your assistance. If you are interested, please send your contributions to Dr. Robert W. Emery, 780 Chestnut St., Springfield, Ma. 01107. □

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TEL-MED

Physicians and sometimes dentists are criticized for "not giving their patients enough information." These critics claim that they treat patients without providing additional facts and interesting chatter that would assist in recovery or reassurance.

One dramatic disproof of this criticism is the willingness of medical and dental societies across Massachusetts to co-sponsor new telephone-based health information services. These "Tel-Med" services have been a useful service to patients.

Massachusetts local medical and dental societies are following the example of the San Bernardino County Medical Society in agreeing to sponsorship. The California society developed the first Tel-Med service in 1972 with the help of federal funds.

Since then, the number of services has catapulted to nearly 200, attracting hundreds of thousands of telephone calls annually from Americans. In Massachusetts, three such services have been sponosred jointly by professional societies and Blue Cross and Blue Shield.

The first Tel-Med service on the East Coast was started in Boston in 1974 with the assistance and support of the Suffolk District Medical Society. Other sponsors included Blue Cross and Blue Shield, the City of Boston and the Tri-State Regional Medical Program.

Another was started in November of 1977 with the assistance of the Worcester District Medical Society. Dr. Lester Felton, president of the society at the time, was quoted publicly as saying his society, "endorses this and thinks it is a good program."

The local Hampden District Medical Society co-sponsored an additional service which opened in Springfield on November 30, 1978. Besides Blue Cross and Blue Shield, other sponsors included the Massachusetts Dental Society, Massachusetts Psychological Association and city health department.

The Tel-Med system is designed to distribute sometimes confidential information in a manner that puts the callers at ease. Probably the most significant factor with Tel-Med is that people calling the services need not give their names.

Callers need not even ask questions about their topic of concern. They can simply call and ask for a tape recording by number. The tape recording is made by a young or old, male or female reader to match the type of caller using the tape.

Some of the most popular tapes are those concerning "sensitive" subjects such as venereal disease, birth control, pregnancy, and psychiatric illness. Sometimes people call these tapes to get information they feel uncomfortable getting from friends.

In Springfield, open hours of the service have been expanded to improve access to the tape information. Now people can call 24 hours a day, seven days a week and listen to any of the 200 tape recordings available.

There is strong physician/dentist involvement in the production of the tapes. They are either written by the professionals or screened by physicians and dentists before Tel-Med in California will allow them to be played.

Publicity issued about the Tel-Med system has repeatedly urged that people use Tel-Med only as an informational and educational tool. Brochures include a disclaimer saying tapes are not to be used in an emergency, to diagnose an illness or replace physicians or dentists.

The range of topics in each of the Tel-Med systems is extensive. It includes such serious illnesses as cancer or heart disease, but also less dangerous ones as bee sting and earache. Each tape lasts about three to five minutes.

The key to the use of the Tel-Med system is the tape directory. Without it, people do not know what tapes are available, and do not know the numbers of the tapes they want. The effort to distribute these lists has been extensive.

Brochures are made available without charge to schools, libraries and any non-profit or civic organizations. Tel-Med brochures may be obtained by writing Blue Cross and Blue Shield at 77 Boylston Street, Springfield, 01104, or at P.O. Box 2097, Boston, 02106. Lists are available in quantity to public service organizations or employers.

Some physicians groups and hospitals have taken steps to make it easier for people to obtain the intersting information in the Tel-Med tapes. They have installed telephones in their waiting rooms which connect directly to the Tel-Med switchboard.

These "direct lines" come complete with a wall display listing tape numbers and have helped to both relieve waiting time and also give patients information aobut their particular problem before and after they have it treated by their physician. □

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This protection would come through private health insurance. Most persons would receive this insurance through their employment. Their employers would be required to offer the full-benefit coverage to their employees and their families, and pay at least 65% of the premium--and many employers would no doubt continue the practice of paying more. The employee would pay any difference.

Low-income or unemployed persons would obtain the same full coverage from their own insurance companies, and the government would contribute toward the premium. The government would pay all of the insurance premium for the poor, and gradually less for others on a scale related to their incomes. As income increased, the federal assistance would diminish.

Elderly individuals would also be able to obtain private insurance to build up the level of their medicare benefits to the level of the full benefits program, and the government would pay for all or part of such insurance depending on the individual incomes.

There would be some coinsurance, to keep costs of the program down, except that the poor would pay nothing. Any coinsurance that an individual or family would have to pay in any year would be limited in relation to their income, but even this would be further limited by a fixed amount applicable to all persons. The limit on the amount any individual or family would have to pay in any year would assure against any economic hardships because of costly illness. There would be no deductible; benefits would begin immediately.

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No special taxes would be needed to finance the program. Financial participation of the government would be very limited, and would come primarily as payment of premium for the poor and premium assistance for individuals or families with low incomes. As is true today, most of the premium for comprehensive health insurance protection would come from employee group insurance, and employers would pay the major part of that premium. Subsidies would be available to assist employers experiencing substantially increased costs.

Adoption of this program would assure continuation of the advantages of our system of health care and the quality of such care. The individual would choose his physican and the method under which he would receive his health care, and his insurance would provide him the full protection--both basic and catastrophic--he needs against the costs of illness. □

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The Board will accept re-certification by a specialty board which meets or exceeds AMA or AOA criteria for continuing medical education within the immediately preceeding three years. This means that anyone who has become Board re-certified between 1977 and 1980 has fulfilled the Board's requirement for re-registration in 1980.

If you have any questions regarding this matter, do not hesitate to contact us. □

Yours truly,

CHARLOTTE B. CLOUTIER, M.A.
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